



P.O. BOX 323  
SOUTHFIELD MI 48037  
[WWW.CAAHP-USA.ORG](http://WWW.CAAHP-USA.ORG)

## **2019 MEMBERSHIP APPLICATION**

Renewal \_\_\_\_\_ or New Member(s) \_\_\_\_\_ (check one)

Name (1): \_\_\_\_\_

Name(2) (if applicable): \_\_\_\_\_

Degree (1): MD DO DDS RPH Pharm D PA RN NP Other: \_\_\_\_\_  
(Circle One)

Degree (2): MD DO DDS RPH Pharm D PA RN NP Other: \_\_\_\_\_  
(Circle One)

Do you have an active license? Yes / No

For students and residents, list year of graduation from school/residency: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (cell): \_\_\_\_\_

Telephone (work): \_\_\_\_\_

Email: \_\_\_\_\_ (Required)

Signature: \_\_\_\_\_

Membership Fees: (Please check one)

\_\_\_\_\_ Active Member (must be fully licensed/registered) - \$125

\_\_\_\_\_ Active Member + Spouse - \$225

\_\_\_\_\_ Active Member + Sibling living in same household - \$225

\_\_\_\_\_ Active Married Members (2 people licensed/registered) - \$225

\_\_\_\_\_ Associate Member (Unlicensed health professional) - \$100 per person

\_\_\_\_\_ Students, Members in training (i.e. resident or fellow) – NO CHARGE

Amount paid \$ \_\_\_\_\_

(Make check payable to CAAHP and mail to PO Box 323, Southfield MI 48037)